PATIENT REGISTRATION FORM

PATIENT INFORMATION					
	Patient Name		Parent/Guardian Name (if applicable)		
	Street Address		City	State	Zip
	Home Ph #	Cell #	Birth Date	Gender	Prior Military Service?
	Occupation	Email		How did you hear about us?	

What is the reason for your visit today?

☐ Routine Exam ☐ Red Eye ☐ Injury
☐ Glasses ☐ Contact Lenses ☐ Follow-Up

When was your last eye exam? _____ **Where was your last eye exam?** _____

Current vision correction:

☐ None ☐ Glasses ☐ Contact Lenses

Are you currently taking any medications/vitamins/birth control?

☐ YES ☐ NO If yes, please list: _____

_____

Allergies (medications, foods, latex, others):

☐ YES ☐ NO If yes, please list: _____

_____

Do you use Alcohol? ☐ Yes ☐ No Cigarettes/Tobacco? ☐ Yes ☐ No

PATIENT HISTORY

Please indicate any conditions that YOU have or have had in the past (please check all that apply):

☐ Glaucoma	☐ Headaches	☐ Asthma
☐ Macular Degeneration	☐ Diabetes	☐ Nervous System Disorders
☐ Retinal Detachment	☐ High Blood Pressure	☐ Mental Health Issues
☐ Crossed/"Lazy" Eye	☐ High Cholesterol	☐ Arthritis
☐ Flashes/Floaters	☐ Heart Disease	☐ Skin Disorders
☐ Eye Infection	☐ Kidney Disease	☐ Cancer
☐ Eye Surgeries	☐ Stroke	☐ Pregnant/Nursing (CURRENTLY)
☐ Eye Trauma	☐ Thyroid Disorder	☐ Other
☐ Double Vision	☐ Liver Disease	

Name of primary care physician: _____ Date of last visit _____

FAMILY HISTORY

Please indicate any conditions that run in your family (please check all that apply):

	Relationship?		Relationship?
☐ Glaucoma	_____	☐ High Blood Pressure	_____
☐ Macular Degeneration	_____	☐ Diabetes	_____
☐ Retinal Detachment	_____	☐ Cancer	_____
☐ Crossed/"Lazy" Eye	_____	☐ Thyroid Disorder	_____
☐ Other Eye Conditions	_____	☐ Other Medical Conditions	_____

Dilation:

Eye drops are used to temporarily increase the size of the pupils. This allows the doctor to evaluate your eyes for disease such as glaucoma, macular degeneration, diabetic complications, and other peripheral anomalies. Effects of dilation last 4-6 hours (up to 24 hours in children) and side effects may include light sensitivity, blurred vision (most noticeable at near), and large pupils. I have read and understand the importance and effects of dilation.

☐ **I give the doctor my consent to dilate my eyes/my child (if patient is under 18) if they feel it is necessary.**

☐ **I decline dilation today and understand that I might be at risk for undetected eye conditions.**

Signature _____ **Date** _____

Billing, Notice of Privacy Practices, and Authorization

1. Payment

I accept financial responsibility for all payments for services received. Payment will be collected at the time of services and can be made in the form of cash, check, or debit/credit. Any check returned due to insufficient funds will be subject to a $30 penalty. Contact lens fitting is not included in a routine eye exam. It is a separate procedure with an additional charge.

2. Privacy Act and Provider Notice of Information Practices

HIPPA Law (**H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996) requires that each patient be provided a copy of our Notice of Privacy Practices upon request. This document describes in detail how information about you, the patient, can be used within our office and with others who need to know for the reason of treatment, payment, and/or health care operations.

I understand that the information given by me and/or collected and stored in my health record is necessary for Breena Dell Clayton, OD and other all other associated optometrists to provide services for my health and well-being. I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person, unless specified as routine use, without my signed consent.

We can have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and obligations under that law. You have the right to receive a copy of our most current NOTICE in effect if you so choose.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand and agree that Breena Dell Clayton, OD and other license optometrists associated with this practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the notice of Privacy Practice, and I understand that Breena Dell Clayton, OD and all other licensed optometrists associated with this practice are not required by law to agree to such requests.

Costco Employees and Dependents ONLY:

3. Authorization to Release Information for Billing Purposes:

I authorize Breena Dell Clayton, OD, an Independent Doctor of Optometry, and all other licensed providers practicing within this location to disclose medical information, i.e. diagnosis, discharge summary, doctor's orders, progress notes, and other related documents to the extent required to assure payment from contracted payers.

By signing below, I agree that I have reviewed and understand the information above.

Signature: _____

Date: _____